SERFF Tracking Number:	*PRUD-126871133*	*State:*	*Arkansas*
Filing Company:	*The Prudential Insurance Company of America*	*State Tracking Number:*	*47104*
Company Tracking Number:	*IIGHGRP114027-RP-AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Individual Long Term Care Insurance*		
Project Name/Number:	*ILTC-4 ESP Application Revision/*		

Filing at a Glance

Company: The Prudential Insurance Company of America

Product Name: Individual Long Term Care Insurance	SERFF Tr Num: PRUD-126871133	State: Arkansas
TOI: LTC03I Individual Long Term Care	SERFF Status: Closed-Approved	State Tr Num: 47104
Sub-TOI: LTC03I.001 Qualified	Co Tr Num: IIGHGRP114027-RP-AR	State Status: Closed
Filing Type: Form		Reviewer(s): Marie Bennett, Harris Shearer
	Author: Raenonna Ransom	Disposition Date: 10/25/2010
	Date Submitted: 10/21/2010	Disposition Status: Approved
Implementation Date Requested: On Approval		Implementation Date:
State Filing Description:		

General Information

Project Name: ILTC-4 ESP Application Revision	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: Filed Concurrently
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 10/25/2010	Explanation for Other Group Market Type:
	State Status Changed: 10/25/2010
Deemer Date:	Created By: Raenonna Ransom
Submitted By: Raenonna Ransom	Corresponding Filing Tracking Number: PRUD-125558856

Filing Description:
Individual Long Term Care Insurance - ILTC-4 ESP Application Revision

Company and Contact

Filing Contact Information

Karen Smyth, Vice President	karen.smyth@prudential.com
2101 Welsh Road	215-658-6279 [Phone]

SERFF Tracking Number:	*PRUD-126871133*	*State:*	*Arkansas*
Filing Company:	*The Prudential Insurance Company of America*	*State Tracking Number:*	*47104*
Company Tracking Number:	*IIGHGRP114027-RP-AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Individual Long Term Care Insurance*		
Project Name/Number:	*ILTC-4 ESP Application Revision/*		

Dresher, PA 19025 888-294-6332 [FAX]

Filing Company Information

The Prudential Insurance Company of America	CoCode: 68241	State of Domicile: New Jersey
751 Broad Street	Group Code: 304	Company Type: Life
Newark, NJ 07102-3777	Group Name:	State ID Number:
(973) 802-6000 ext. [Phone]	FEIN Number: 22-1211670	

Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Prudential Insurance Company of America	$50.00	10/21/2010	41016054

SERFF Tracking Number:	*PRUD-126871133*	*State:*	*Arkansas*
Filing Company:	*The Prudential Insurance Company of America*	*State Tracking Number:*	*47104*
Company Tracking Number:	*IIGHGRP114027-RP-AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Individual Long Term Care Insurance*		
Project Name/Number:	*ILTC-4 ESP Application Revision/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Marie Bennett	10/25/2010	10/25/2010

SERFF Tracking Number:	*PRUD-126871133*	*State:*	*Arkansas*
Filing Company:	*The Prudential Insurance Company of America*	*State Tracking Number:*	*47104*
Company Tracking Number:	*IIGHGRP114027-RP-AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Individual Long Term Care Insurance*		
Project Name/Number:	*ILTC-4 ESP Application Revision/*		

Disposition

Disposition Date: 10/25/2010
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*PRUD-126871133*	*State:*	*Arkansas*
Filing Company:	*The Prudential Insurance Company of America*	*State Tracking Number:*	*47104*
Company Tracking Number:	*IIGHGRP114027-RP-AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Individual Long Term Care Insurance*		
Project Name/Number:	*ILTC-4 ESP Application Revision/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Supporting Document	Filing Cover Letter - 10-21-2010		Yes
Form	ILTC-4 ESP Application		Yes

SERFF Tracking Number:	*PRUD-126871133*	*State:*	*Arkansas*
Filing Company:	*The Prudential Insurance Company of America*	*State Tracking Number:*	*47104*
Company Tracking Number:	*IIGHGRP114027-RP-AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Individual Long Term Care Insurance*		
Project Name/Number:	*ILTC-4 ESP Application Revision/*		

Form Schedule

Lead Form Number: GRP 114027

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	GRP 114027	Application/ Enrollment Form	ILTC-4 ESP Application	Initial		50.700	GRP 114027 - ILTC-4 NP ESP Application. - 10-2010.pdf

Prudential

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

LONG TERM CARE CUSTOMER SERVICE CENTER

PO BOX 8519
PHILADELPHIA PA 19176-8519
1.800.732.0416

LONG TERM CARE INSURANCE APPLICATION FOR EMPLOYER SPONSORED PROGRAM (ESP)

☐ **New Policy - Partnership** ☐ **Reinstatement**
☐ **New Policy - Non-Partnership** ☐ **Employer Sponsored Program (ESP)**
☐ **Coverage Change** **Type of Coverage:** ☐ **Employee**

(Indicate Current Policy Number if Coverage Change or Reinstatement request)

TO: THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

Please print all information except where signatures are required. Use black ink. Read all questions carefully.

APPLICANT INFORMATION

☐ Mr. ☐ Ms. ☐ Mrs. ☐ _____ ___-___-___ ☐ Male ☐ Female
Applicant's Social Security #

First Name M.I. Last Name
(As it should appear on your Policy)

Street Address (No PO Boxes) Apt. No.

City State Zip Code

___-___-___ Age ___-___-___ ___-___-___
Date of Birth Daytime Phone Evening Phone

IF THE MAILING ADDRESS IS OTHER THAN THE ADDRESS GIVEN ABOVE, PLEASE COMPLETE THE FOLLOWING:

Address Apt. No.

City State Zip Code

Best Time to Call ☐ AM ☐ PM Marital Status ☐ Yes, married ☐ No, not married
Is your Spouse/Partner applying for this insurance? ☐ Yes ☐ No
If No, does he/she currently have Prudential Long Term Care insurance? ☐ Yes ☐ No

If Yes, give Policy/Certificate Number

Spouse/Partner First Name M.I. Last Name

___-___-___ ☐ Spouse ☐ Partner
Spouse/Partner Social Security #

INSURANCE HISTORY — Indicate yes or no

If coverage is being replaced, please submit a completed Replacement Notice.

1 Are you covered by Medicaid or Medi-Cal (not Medicare)? ☐ Yes ☐ No

2 Do you have other long term care or accident and sickness insurance in force (including policies, certificates, health care service contracts, or health maintenance organization contracts)? ☐ Yes ☐ No

3 Did you have other long term care insurance in force during **the last 12 months**? ☐ Yes ☐ No

4 Do you intend to replace any of your medical health insurance with this insurance? ☐ Yes ☐ No

IF YOU ANSWERED YES TO QUESTIONS 2, 3, OR 4 OF THIS SECTION, PLEASE PROVIDE THE FOLLOWING INFORMATION

☐ Group
☐ Individual
Type of Coverage _____ Policy # _____
Intend to replace? ☐ Yes ☐ No Did insurance lapse? ☐ Yes ☐ No If yes give date _____

☐ Group
☐ Individual
Type of Coverage _____ Policy # _____
Intend to replace? ☐ Yes ☐ No Did insurance lapse? ☐ Yes ☐ No If yes give date _____

_____

Full name and address of insurance company

MEDICAL HISTORY – PART 1 INSURABILITY PROFILE — Indicate yes or no

☐ Yes ☐ No 1 Within the past 12 months have you used any of the following:
☐ Wheelchair ☐ Motorized Scooter ☐ Walker ☐ Crutches ☐ Quad Cane
☐ Oxygen ☐ Respirator ☐ Kidney Dialysis

☐ Yes ☐ No 2 Within **the past 12 months** have you utilized, or been advised to utilize any of the following:
☐ Adult Day Care ☐ Assisted Living Facility ☐ Other long term care facility
☐ Home Health Care ☐ Nursing Home

☐ Yes ☐ No 3 Do you currently need or receive human assistance or supervision with any of the following:
☐ Bathing ☐ Eating ☐ Toileting ☐ Bowel or Bladder Control
☐ Dressing ☐ Taking Medication ☐ Walking
☐ Moving in or out of bed or chair

4 Have you ever been diagnosed with or have you consulted a health care professional or received medical advice for:

☐ Yes ☐ No a Organic Brain Syndrome, Dementia, Senility, Confusion, Memory Loss, Alzheimer's Disease, Schizophrenia, or Mental Retardation?

☐ Yes ☐ No b Metastatic cancer (cancer which has spread from original site)?

☐ Yes ☐ No c Multiple Sclerosis (M.S.), Muscular Dystrophy, Parkinson's Disease, Huntington's Disease, Post Polio Syndrome, Lou Gehrig's Disease, (ALS) or other chronic neurological Disease/Disorder, Stroke, (CVA), more than one Transient Ischemic Attack (TIA), or Kidney Failure?

☐ Yes ☐ No d Diabetes (Type I or Type II) with kidney condition, heart condition, amputation or any complications of nerves or eyes.

☐ Yes ☐ No 5 Have you ever had or ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), or a Human Immunodeficiency Virus (HIV) Infection?

Attention Agent: The above conditions are uninsurable.

☐ Yes ☐ No 6 Do you have Type I Diabetes (without complications) OR within the last 12 months have you been hospitalized or within the last 24 months have you applied for or received any form of Disability or Workman's Compensation or been declined for Long Term Care insurance?

Attention Agent: If only question #6 is answered yes, the applicant may be eligible for coverage but must submit long application and is subject to full Underwriting

NOTIFICATION OF UNINTENTIONAL LAPSE

You can provide Prudential with the name of a friend or relative to notify if your Policy should lapse because the premium is not paid when due. This designation does not constitute an acceptance of liability by the person named. Prudential will notify you periodically of your right to designate or change the existing designation for this purpose.

ONLY COMPLETE THE APPROPRIATE SECTION: NAME A DESIGNEE OR WAIVER OF NOTIFICATION.

☐ **Check here ONLY to name a designee, and provide the requested information about that person:**

First Name | M.I. | Last Name

Street Address | Apt. No.

City | State | Zip Code

☐ **Check here only if you do not wish to name a person for this purpose and sign below.**

WAIVER OF NOTIFICATION OPTION:

I understand that I have the right to name at least one person other than myself to receive notice of lapse or termination of my long term care insurance policy for non-payment of premium. I understand that notice will not be given until thirty-one days after the premium is due and not paid.
By my signature, I elect NOT to name any person to receive such notice.

X _____
Applicant Signature

ACTIVELY AT WORK STATUS

I certify that my eligibility status as an actively-at-work employee, working at least 25 hours per week, is true and correct as of the date this form is completed.

Name of Employer: _____ Employer Phone Number: _____

Employer Address: _____

X _____
Signature of Applicant Date

_____
Printed Name of Applicant

TO RESIDENTS OF ILLINOIS

The policy is not approved for Medicaid Asset Protection under the Illinois Long Term Care Partnership Program. However, the policy is an approved long term care policy under state insurance regulations. For information about policies approved under the Illinois Long Term Care Partnership Program, call the Senior Help-Line at the Illinois Department on Aging at 1.800.252.8966.

TO RESIDENTS OF IOWA

The policy does not qualify for Medicaid Asset Protection under the Iowa Long Term Care Asset Preservation Program. However, the policy is an approved long term care policy under state insurance regulations. For information about policies and certificates qualifying under the Iowa Long Term Care Asset Preservation Program, call the Senior Health Insurance Information Program of the Iowa Division of Insurance at 1.800.351.4664.

The following does not apply to KS, NJ, OR or VA Residents. Caution: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, may commit a fraudulent insurance act, which is a crime that may subject such person to criminal and/or civil penalties. With respect to New York Residents, civil penalties not to exceed $5,000, plus the stated value of the claim for each violation, can apply.

Note to residents of New Jersey: Caution: Any person who includes any false or misleading information on an application for coverage under a group policy is subject to criminal and civil penalties.

Note to residents of Virginia: Caution: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

APPLICANT AGREEMENTS

Caution: If your answers on this Application are incorrect or untrue, or fail to include all material medical information requested, Prudential may have the right to deny benefits or rescind your Policy. I understand and agree that:

1 To the best of my knowledge and belief, the answers on this Application are complete and true.

2 This Application will be part of the Policy for which I am applying to **The Prudential Insurance Company of America** (Prudential).

3 A Policy will **not** take effect unless: Prudential has approved this Application; the first full modal premium has been paid prior to the Effective Date; and only if the statements and answers given in applying for this Policy are without material change until the date this Application is approved.

4 If issued, my Long Term Care Insurance Policy will take effect on the Effective Date assigned by Prudential.

5 Prudential has the right to change premium rates in the future but only on a class basis.

6 I have received the Outline of Coverage and *A Shopper's Guide to Long Term Care Insurance* from the Agent.

7 If I am eligible for Medicare, I have received the *Guide to Health Insurance for People with Medicare* from the Agent.

8 I have read, or have had read to me, the completed Application, and where applicable, Potential Rate Increase Disclosure Form, and I understand that any false statement or misrepresentation in my Application may result in loss of coverage under the Policy.

9 **INFLATION:** I have reviewed the Outline of Coverage and the graphs that compare benefits and premiums of this Policy with and without inflation protection. Specifically, I have reviewed 5% Automatic Compound Increase Option Rider or the Automatic Compound Inflation Rider - No Max.
☐ **Check this box if you REJECT the Automatic Compound Inflation Benefit Rider - No Maximum, or the 5% Automatic Compound Increase Option Rider.**

10 **NON FORFEITURE:** I have reviewed the Outline of Coverage and the Nonforfeiture benefit described therein. Specifically, I have reviewed this optional benefit available to me.
☐ **Check this box if you REJECT the Shortened Benefit Period Rider Nonforfeiture Benefit.**

11 **Electronic Funds Transfer Authorization (EFT) if applicable:**
Enclose a check for two month's premium.
I authorize Prudential to make deductions from my bank account for payment of premiums. I understand that: 1) Prudential shall not incur any liability on a draft returned by the bank; 2) amounts not clearing after their initial deposit shall constitute non-payment of premium and coverage under the Policy shall lapse subject to its provisions; and 3) authorization shall remain in force until I revoke by signed writing to Prudential or Prudential revokes in accordance with Policy.

BANK (Credit Union) NAME: _____

BANK ACCOUNT #: _____

BANK ROUTING #: _____

TYPE ACCOUNT: ☐ Checking ☐ Savings

BILL DATE*: ☐ 1st ☐ 8th ☐ 15th ☐ 22nd *If no choice is indicated, bill date will default to the 1st of the month.

12 **For Spouse or Partner Only:**
If "Spouse" box is checked on page 1, I certify that my eligibility status as an actively-at-work spouse or Partner, working at least 25 hours per week, as indicated on this Application is true and correct as of the date this form is completed.

Name of employer: _____ Employer Phone Number: _____

X _____
Applicant Signature Date

X _____
Witness (licensed and appointed agent)

_____
Agent (print name) Agent's Contract Number

_____
Signed at: City State

IF PAYMENT IS TO BE MADE VIA PAYROLL DEDUCTION PLEASE COMPLETE THE FOLLOWING:

APPLICANT INFORMATION

First Name M.I. Last Name Applicant's Social Security # ___-___-___

I authorize all deductions for this applicant and other applicants for whom I am authorizing deductions. I understand such deductions will appear on my payroll/earning statement. I understand that I may keep this coverage even if I decide to change jobs. My coverage will remain in effect as long as I continue to pay my premiums on a timely basis and do not exhaust my benefits.

X _____
Applicant Signature Date

SERFF Tracking Number:	*PRUD-126871133*	*State:*	*Arkansas*
Filing Company:	*The Prudential Insurance Company of America*	*State Tracking Number:*	*47104*
Company Tracking Number:	*IIGHGRP114027-RP-AR*		
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Individual Long Term Care Insurance*		
Project Name/Number:	*ILTC-4 ESP Application Revision/*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachment:
AR - Readability Certification - 10-2010.pdf

Item Status: **Status Date:**

Bypassed - Item: Application
Bypass Reason: N/A - this is not a product filing.
Comments:

Item Status: **Status Date:**

Bypassed - Item: Health - Actuarial Justification
Bypass Reason: N/A - this is not a product filing.
Comments:

Item Status: **Status Date:**

Bypassed - Item: Outline of Coverage
Bypass Reason: N/A - this is not a product filing.
Comments:

Item Status: **Status Date:**

Satisfied - Item: Filing Cover Letter - 10-21-2010
Comments:
Attachment:
AR Filing Letter - 10-21-2010.pdf

C E R T I F I C A T I O N
OF
R E A D A B I L I T Y

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA hereby certifies that this filing complies with Arkansas Code ACA 23-80-206, Policy Language Simplification Standards and achieves a Flesch reading ease test score as shown below.

Signature

Karen L. Smyth
Name

Vice President
Title

October 21, 2010
Date

Line of
Insurance: **Health Insurance**
Subline: **Long Term Care**

Policy Form Number/s:

FORM NUMBER	SCORE
GRP 114027	50.7

Karen L. Smyth, FLMI, ACS, AIAA, AIRC, CLTC, LTCP
Vice President
Group Insurance

The Prudential Insurance Company of America
Long Term Care Unit
2101 Welsh Road
Dresher, Pennsylvania 19025
Tel 215 658-6279 Fax 888 294-6332

October 21, 2010

The Honorable Jay Bradford
Commissioner of Insurance
Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

Re: NAIC Number 304-68241
Individual Long Term Care Insurance Product
Form Number: GRP 114027

Dear Commissioner Bradford:

In support of our Employer Sponsored Program, we enclose for your review and approval, the revised insurance form listed above. This form was previously reviewed and approved by the Department on October 1, 2008 – (SERFF PRUD-125558856).

This form represents Prudential's individual long term care insurance product lines and will be marketed through licensed agents or other state licensed insurance producers to residents of your state. It is a modified guaranteed issue form (short form) intended for use with employees when we offer our currently marketed individual long-term care insurance policies; Form GRP 114018, et al, and Form GRP 113096, et al, to an employer group. (Form GRP 114018, et al, was previously approved by the Department on October 1, 2008, and Form GRP 113096, et al was previously approved by the Department on April 14, 2005.)

Changes to this form are as follows:

- The underwriting questions 4d and 6, listed under the "Medical History – Part 1 Insurability Profile" section on page 2, have been expanded to better phrase the questions being asked.
- Page 3 - we have also added an additional "actively-at-work" disclosure.

In view of the above explanation, we are requesting your re-approval of this form with the amendments as explained above. I also certify that with the exception of the changes mentioned above, there have been no other changes made to this form.

If there are any additional questions regarding this filing or you require further information, please do not hesitate to contact my associate:

Raenonna Prince, CLTC, LTCP
Lead Analyst
The Prudential Insurance Company of America
2101 Welsh Road, LTC Unit
Dresher, PA 19025
Voice: (800) 732-0416 or (215) 658-6281
Fax: (888) 294-6332
e-mail: raenonna.prince@prudential.com

Very truly yours,

Karen L. Smyth
Vice President

Enclosure